Medical Health Questionnaire

Name:	
Date of Birth:	
Email address:	

Please indicate the best way to contact you: ☐ email ☐ phone

Present and Past Medical History (please check all that apply)

Please list date of occurrence of below event/s on line provided.

❒ Myocardial infarction _____
❒ PCI/Stents _____
❒ CABG (bypass) _____
❒ CHF
❒ Arrhythmia
❒ Heart Transplant _____
❒ Stable Angina
❒ Hypertension
❒ Hypercholesterolemia
❒ Cardiomyopathy
❒ Diabetes (Type 1/Type2)
❒ Peripheral Vascular Disease
❒ COPD/emphysema
❒ Chronic Bronchitis
❒ Asthma
❒ Stroke _____
❒ Cancer_____
❒ Sleep Apnea
❒ Pacer/ICD/Valve
❒ Post-event complications (Arrest, CHF, bleeding, etc)_____

❒ Recent Surgery (last 12 months) _____

❒Other_____

Other Information (please check all that apply)

❒ Unexplained shortness of breath
❒ Dizziness/Lightheadedness
❒ Sedentary Lifestyle
❒ Anxiety
❒ Leg pain with walking
❒ Arthritis
❒ Osteoporosis
❒ Swelling in your legs or ankles
❒ Palpitations
❒ Family History of Heart Disease
❒ Depression
❒ ADD/ADHD
❒ Substance Abuse/History

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Do you have any orthopedic concerns (known bone, joint, or muscular concern – including arthritis) that staff should be aware of?

Please explain: _____

_____

_____

_____

Are there any conditions or information not listed above that you feel the staff should be aware of? If yes, please explain: _____

_____

_____

Exercise:

Have you ever exercised regularly? ☐ Yes ☐ No If yes, please explain:

Please list up to 3 fitness goals that you would like to achieve. On a scale from 0 (not confident) to 10 (completely confident), how confident are you that these goals can be achieved?

1. _____

2. _____

3. _____

Medical Health Questionnaire

Current Medications

First Name: _____ Last Name: _____
Birth date: _____

Name of Medication	Dosage	Reason for Taking

Do you have any known allergies to foods, medications, etc.?

☐ Yes ☐ No

If yes, explain:

_____

Date and place of examination:

_____